

## HOSPICE RECIPIENT STATUS CHANGE

DATE: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Contact Fax Number: \_\_\_\_\_

The following change information is being routed for review and processing

Recipient Name: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Revocation or Discharge of Hospice Benefit

Date: \_\_\_\_\_

Reason for Revocation or Discharge: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dually Eligible Institutionalized Recipient	Medicaid Only Institutionalized Recipient
<input type="checkbox"/> Initial NH Admit Date of Admission:	
<input type="checkbox"/> Discharged from NH to Hospital Effective Date:	<input type="checkbox"/> Discharged from NH to Hospital Effective Date:
<input type="checkbox"/> Discharged from NH to Community Effective Date:	<input type="checkbox"/> Discharged from NH to Community Effective Date:
<input type="checkbox"/> Expired in NH Effective Date:	<input type="checkbox"/> Expired in NH Effective Date:
<input type="checkbox"/> Readmitted to NH from Hospital Effective Date:	

**Confidentiality Warning:** This document is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you have received this communication in error, please notify us immediately by telephone (1-800-362-1504) or FAX the document to us noting that you received it in error.